

but not less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to 50 percent of the difference between 97 percent of the target amount and the allowable costs; and

(2) When a QHP's allowable costs for any benefit year are less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the allowable costs.

**§ 153.520 Attribution and allocation of revenue and expense items.**

(a) *Attribution to QHP.* Each item of revenue or expense in allowable costs or the target amount with respect to a QHP must be reasonably attributable to the operation of the QHP, with the attribution based on a generally accepted accounting method, consistently applied. To the extent that an issuer utilizes a specific method for allocating expenses for purposes of § 158.170 of this subchapter, the method used for purposes of this paragraph must be consistent.

(b) *Allocation across plans.* Each item of revenue or expense in allowable costs or the target amount must be reasonably allocated across a QHP issuer's plans, with the allocation based on a generally accepted accounting method, consistently applied. To the extent that an issuer utilizes a specific method for allocating expenses for purposes of § 158.170 of this subchapter, the method used for purposes of this paragraph must be consistent.

(c) *Disclosure of attribution and allocation methods.* A QHP issuer must submit to HHS a report, in the manner and timeframe specified in the annual HHS notice of benefit and payment parameters, with a detailed description of the methods and specific bases used to perform the attributions and allocations set forth in paragraphs (a) and (b) of this section.

(d) *Attribution of reinsurance and risk adjustment to benefit year.* A QHP issuer must attribute reinsurance payments and contributions and risk adjustment payments and charges to allowable costs for the benefit year with respect to which the reinsurance payments or

contributions or risk adjustment calculations apply.

(e) *Maintenance of records.* A QHP issuer must maintain for 10 years and make available to HHS upon request the data used to make the attributions and allocations set forth in paragraphs (a) and (b) of this section, together with all supporting information required to determine that these methods and bases were accurately implemented.

**§ 153.530 Risk corridors data requirements.**

(a) *Premium data.* A QHP issuer must submit to HHS data on the premiums earned with respect to each QHP that the issuer offers in the manner and timeframe set forth in the annual HHS notice of benefit and payment parameters.

(b) *Allowable costs.* A QHP issuer must submit to HHS data on the allowable costs incurred with respect to each QHP that the QHP issuer offers in the manner and timeframe set forth in the annual HHS notice of benefit and payment parameters. For purposes of this subpart, allowable costs must be—

(1) Increased by—

(i) Any risk adjustment charges paid by the issuer for the QHP under the risk adjustment program established pursuant to subpart D of this part; and

(ii) Any reinsurance contributions made by the issuer for the QHP under the transitional reinsurance program established pursuant to subpart C of this part.

(2) Reduced by—

(i) Any risk adjustment payments received by the issuer for the QHP under the risk adjustment program established pursuant to subpart D of this part;

(ii) Any reinsurance payments received by the issuer for the QHP under the transitional reinsurance program established pursuant to subpart C of this part; and

(iii) Any cost-sharing reduction payments received by the issuer for the QHP.

(c) *Allowable administrative costs.* A QHP issuer must submit to HHS data on the allowable administrative costs incurred with respect to each QHP that the QHP issuer offers in the manner

## § 153.600

and timeframe set forth in the annual HHS notice of benefit and payment parameters.

### Subpart G—Health Insurance Issuer Standards Related to the Risk Adjustment Program

#### § 153.600 [Reserved]

#### § 153.610 Risk adjustment issuer requirements.

(a) *Data requirements.* An issuer that offers risk adjustment covered plans must submit or make accessible all required risk adjustment data for those risk adjustment covered plans in accordance with the risk adjustment data collection approach established by the State, or by HHS on behalf of the State.

(b) *Risk adjustment data storage.* An issuer that offers risk adjustment covered plans must store all required risk adjustment data in accordance with the risk adjustment data collection approach established by the State, or by HHS on behalf of the State.

(c) *Issuer contracts.* An issuer that offers risk adjustment covered plans may include in its contract with a provider, supplier, physician, or other practitioner, provisions that require such contractor's submission of complete and accurate risk adjustment data in the manner and timeframe established by the State, or HHS on behalf of the State. These provisions may include financial penalties for failure to submit complete, timely, or accurate data.

(d) *Assessment of charges.* An issuer that offers risk adjustment covered plans that has a net balance of risk adjustment charges payable, including adjustments made pursuant to §153.350(c), will be notified by the State, or by HHS on behalf of the State, of those net charges, and must remit those risk adjustment charges to the State, or to HHS on behalf of the State, as applicable.

(e) *Charge submission deadline.* An issuer must remit net charges to the State, or HHS on behalf of the State, within 30 days of notification of net charges payable by the State, or HHS on behalf of the State.

## 45 CFR Subtitle A (10–1–12 Edition)

#### § 153.620 Compliance with risk adjustment standards.

(a) *Issuer support of data validation.* An issuer that offers risk adjustment covered plans must comply with any data validation requests by the State or HHS on behalf of the State.

(b) *Issuer records maintenance requirements.* An issuer that offers risk adjustment covered plans must retain any information requested to support risk adjustment data validation for a period of at least ten years after the date of the report.

### PART 154—HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS

#### Subpart A—General Provisions

Sec.

154.101 Basis and scope.

154.102 Definitions.

154.103 Applicability.

#### Subpart B—Disclosure and Review Provisions

154.200 Rate increases subject to review.

154.205 Unreasonable rate increases.

154.210 Review of rate increases subject to review by CMS or by a State.

154.215 Submission of disclosure to CMS for rate increases subject to review.

154.220 Timing of providing the Preliminary Justification.

154.225 Determination by CMS or a State of an unreasonable rate increase.

154.230 Submission and posting of Final Justifications for unreasonable rate increases.

#### Subpart C—Effective Rate Review Programs

154.301 CMS's determinations of Effective Rate Review Programs.

AUTHORITY: Section 2794 of the Public Health Service Act (42 USC 300gg–94).

SOURCE: 76 FR 29985, May 23, 2011, unless otherwise noted.

#### Subpart A—General Provisions

#### § 154.101 Basis and scope.

(a) *Basis.* This part implements section 2794 of the Public Health Service (PHS) Act.